Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

T.E.A.M.S
2646 S LOOP WEST STE 290
HOUSTON TX 77054

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-03-9088-01

MFDR Date Received
JULY 30, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As you can see the enclosed methodology for medical services fees are fair and reasonable and are designed to ensure the quality of medical care and achieve effective medical cost control. This methodology considers similar treatment of injured individual equivalent standard of living and those paid by that individual or by someone acting on the individuals behalf. This program is however: a non mar (hence no established fee guideline) program in the TWCC guidelines and Medicare on its web site appear to be reviewing interdisciplinary programs and at this time have no fee in place for such program… Each individual case dictates both the professionals involved and the amount of involvement of each professional. These programs are greater, more beneficial and more cost effective than they would be individually."

Amount in Dispute: $28,050.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Medical Fee Guidelines list procedure code 97799 as requiring documentation of procedure and provides for reimbursement at a 'fair and reasonable rate'. Liberty Mutual reimburses these services at a fair and reasonable rate of $125 per hour for an accredited provider and $100 per hour for a non CARF-accredited provider. According to the 1996 fee guidelines, documentation is required for services billed with procedure codes designated as DOP."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30503

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2002 – July 25, 2002	CPT Code 97799 – Chronic Pain Management	$28,050.00	$0.00
July 31, 2002 - October 23, 2002			

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 30, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on August 5, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M, Z436 – Chronic Pain Management.
   - F, Z560 – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.
   - X598 – Claim has been reevaluated based on additional documentation submitted; no additional payment due.

Findings

1. In accordance with 28 Texas Administrative Code §133.307(d)(1), effective January 2, 2002, 26 TexReg 10934, states that a request for medical dispute resolution on a carrier denial or reduction, of a medical bill pursuant to §133.304 of this title shall be considered timely if it is filed with the carrier and the division no later than one year after the dates of service in dispute. The requestor submitted the request for medical fee dispute resolution on July 30, 2003; review of the table of disputed services finds dates of service July 23, 2002; July 24, 2002 and July 25, 2002 were not submitted timely. Therefore, these dates of service will not be reviewed.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective May 16, 2002, 27*Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission.
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
5. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
6. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "As you can see the enclosed methodology for medical services fees are fair and reasonable and are designed to ensure the quality of medical care and achieve effective medical cost control. This methodology considers similar treatment of injured individual equivalent standard of living and those paid by that individual or by someone acting on the individuals behalf."

- The requestor does not discuss or explain how the methodology they submitted supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 3, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		August 3, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.